

## § 156.50

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

*Benefit year* has the meaning given to the term in §155.20 of this subtitle.

*Cost-sharing* has the meaning given to the term in §155.20 of this subtitle.

*Cost-sharing reductions* has the meaning given to the term in §155.20 of this subtitle.

*Group health plan* has the meaning given to the term in §144.103 of this subtitle.

*Health insurance coverage* has the meaning given to the term in §144.103 of this subtitle.

*Health insurance issuer or issuer* has the meaning given to the term in §144.103 of this subtitle.

*Level of coverage* means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

*Plan year* has the meaning given to the term in §155.20 of this subchapter.

*Qualified employer* has the meaning given to the term in §155.20 of this subchapter.

*Qualified health plan* has the meaning given to the term in §155.20 of this subchapter.

*Qualified health plan issuer* has the meaning given to the term in §155.20 of this subchapter.

*Qualified individual* has the meaning given to the term in §155.20 of this subchapter.

[77 FR 18468, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

## § 156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

*Participating issuer* means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in §155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in §155.1065 of this subtitle), or

## 45 CFR Subtitle A (10–12 Edition)

other issuers identified by an Exchange.

(b) *Requirement for Exchanges user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by the Federally-facilitated Exchange under 31 U.S.C. 9701 or a State-based Exchange under §155.160 of this subchapter.

## Subpart B—Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

SOURCE: 77 FR 42670, July 20, 2012, unless otherwise noted.

### § 156.120 Collection of data from certain issuers to define essential health benefits.

(a) *Definitions.* The following definitions apply to this section, unless the context indicates otherwise:

*Health benefits* means benefits for medical care, as defined at §144.103 of this chapter, which may be delivered through the purchase of insurance or otherwise.

*Health insurance product* has the meaning given to the term in §159.110 of this chapter.

*Health plan* has the meaning given to the term, “Portal Plan” in §159.110 of this chapter.

*Small group market* has the meaning given to the term in §155.20 of this chapter.

*State* has the meaning given to the term in §155.20 of this chapter.

*Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include only quantitative treatment limitations. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Required information.* The issuers described in paragraph (c) of this section must provide the following information for the health plans described in paragraph (d) of this section in accordance with the standards in paragraph (e) of this section:

(1) Administrative data necessary to identify the health plan;